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HIV AND AIDS IN NIGERIA: A CHALLENGE TO SUSTAINABLE HUMAN DEVELOPMENT IN THE NIGER DELTA REGION

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ABSTRACT

The HIV and AIDS pandemic posses the most significant threat to government planning aspiration in Nigeria. In the Niger Delta the crisis is potentially devastating, one inextricably linked to development. Poor livelihood or poverty in the view of this paper increased vulnerability to the pandemic, while HIV prevalence hinders economic growth and development. The paper revealed that economic, social and cultural factors have spread HIV in the Delta region. Dealing with many dimensions of HIV and AIDS according to the study, requires an integrated approach. All stakeholders-federal, state and local governments, the private sector, civil society organizations and international organizations have roles to play to bring about active preventive and curative programmes.

Keywords: HIV/AIDS, Sexually Transmitted Diseases (STDs) , poverty, Niger Delta.

INTRODUCTION

Africa is currently faced with a grave and degenerative crisis as a result of hiv and aids pandemic. Available records reveal that nine out of every ten new cases of HIV occur in Africa. According to (Gaigbe-togbe and weinberger 2003:1), aids is not only "the deadliest epidemic in continental history, but also a major demographic, humanitarian and development crisis.

By the end of 2002, 42 million people worldwide were infected with HIV, with 25 million already dead from aids. About 95 percent of this total is in the less industrialized world. An estimated 13 million, aids orphans currently live in sub-saharan Africa alone. In 38 African countries (including Nigeria), the united nations population division explicitly incorporated the

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impact of aids into its 2002 population projections. It estimated the total population at 603 million in 1995, with 16 million fewer people than without aids. By 2025, the population of these 38 countries is projected to reach 983 million, a 14 percent shortfall.

Average life expectancy at birth has already fallen by 10 years in the most affected countries-that is, those with an adult HIV prevalence of 20 percent or more (UNDP 2003). The 1995-2000 average life expectancy is estimated at 47 years for these countries, a six- year drop due to aids. By 2020-2025, life expectancy is projected at 52 years only, or 10 years less than could otherwise be predicted.

The challenge of HIV and AIDS in Nigeria

Nigeria first experienced HIV and AIDS in 1986, with the diagnosis of a 13-years old female hawker (UNDP, 2006). Since then, the prevalence of hiv has increased from 1.8 percent in 1990 to five percent in 2003. According to a federal survey carried out in 2001, 5.8 percent of the population (or 7.5 million people) had tested positive for HIV- in other words, six out of every 100 Nigerians, including over one million children.

Currently, Nigeria ranks among the countries at risk of the next stage of the HIV and AIDS pandemic, when prevalence rates begin to skyrocket. The country according to (UNICEF, 2003) has the third largest number of people living with HIV and AIDS in the world, and the highest number of orphans from aids (UNAIDS, 2002), estimated at about 1.2 million in 2003. Between 1986 and June 2001, 52, 962 aids cases were recorded in Nigeria, although this is a gross underestimation due to under reporting by private health facilities, the fear of stigma, under-diagnosis and the limited use of health care facilities (government of Nigeria 1999). Aids deaths in the country were projected to as high as 850,000 adults and children by the end of 2001 (Government of Nigeria 2002:6). Available statistics, according to UNAIDS estimates show that as many as 3.5 million Nigerians may be living with aids.

According to (Alubo, et al, 2002:118), these grim statistics are only the proverbial tip of the iceberg. Worsening mortality is reversing gains in life expectancy accompanied through decades of programmes like the expanded programme on immunization. Rural impoverishment has steadily worsened as the epidemic intensifies the ratio between dependent and workers. These trends make the development implications of HIV and AIDS very grave.

In the Niger Delta when combined with the prospects for an eco-catastrophe, the crisis is potentially devastating. The epidemic impedes sustainable human development by destroying the family as the basic unit of society; weakening the educational system; which nurtures the next generation of leaders; threatening agricultural productivity and food security; impeding industrial

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capacity; and overwhelming the health care system. The disease erodes human capacity, which is a principal building block of development, by raising attrition among farmers, teachers, and other groups to rates that cannot be managed (see UNDP, 2006).

The effect of long illness and premature death within the economically active work force have profound economic implications causing acute labour shortages at household and community levels, altering established relations between, (labour, land and capital; changing established community patterns in the transmission agricultural knowledge between generations, and distorting the age range of agricultural workers. A high rate of HIV/AIDS also leads to irreversible drops in rural house hold assets and reversals in rural capital flows. (Erinosho, 2004). Furthermore, community structures weaken and safety nets are strained. The resilience of farming and livelihood systems diminishes, vulnerability to food shortages increases and households have less of a capacity to recover from disasters that occur. In dealing with the burden from HIV and AIDS, people lose time and opportunities they might otherwise have had in a world without the disease (Gaigbe- togbe et al, 2003).

The prevalence of HIV and AIDS in the Nigeria Delta

The prevalence of HIV and AIDS in the Niger Delta is among the highest Nigeria, higher than, the average for the country (Nigeria) as a whole (see table 1 below. The 2003 sentinel survey rated the south-south region as having the second highest prevalence (5.8 percent), after the north central with 7%. This result is alarming compared to the south west at 2.3 percent and the north-west at 4.2 percent. The delta has an average prevalent rate of 5.3 percent, compared to the national average of five percent.

Table 1: HIV and AIDS prevalence in the Niger Delta,

1999-2003

States	Prevalence rates	Percent	
	1999	2001	2003
Abia	3.0	3.3	3.7
Akwa ibom	12.5	10.7	7.2
Bayelsa	4.3	7.2	4.0
Cross river	5.8	8.0	1.20
Delta	4.2	5.8	5.0
Edo	5.9	5.7	5.0
Imo	7.8	4.3	3.1
Ondo	2.9	6.7	2.3
Rivers	3.3	7.7	6.6
Nigeria		5.7	4.8

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Source: Technical report, National HIV and AIDS sentinel survey, 2004 – HIV and AIDS.

Nearly half the delta states (Akwa Ibom, Cross River, Delta and Rivers, have either the same or higher prevalence rates as the national average. The Niger Delta and national rates rose from 1999 to 2001, but declined in 2003. The decline might not be an indication of successful strategies to stop HIV and AIDS, however. Official statistics over this period show a declining number of births attended to by trained medical practitioners, which is relevant given that the prevalence rate is obtained through sentinel surveys. Some experts contend that fewer Nigerians are taking voluntary tests for HIV.

There are serious variations in the distribution of HIV and AIDS among the nine states of the Niger Delta. Prevalence rates range from 2.3 percent in Ondo to 12 percent in cross river states. Part of the reasons for the variations is that the latter state is bordered on three out of four sides by states with a prevalence level of six percent or more. In the north, Cross River shares boundaries with Benue state, with a prevalence of 9.3 percent. Prevalence levels increased dramatically as one moves from the south- west to the south-east of Nigeria, where industrial activities related to oil exploration are most intensive.

The impacts of HIV and AIDS has been particularly harsh in the Niger Delta. It is well known that the disease wreaks greater havoc where there is poverty, social inequality and general political marginalization. Inadequate health systems prevent the management of the epidemic. The weakening of livelihood and the social fabric in areas prone to oil exploitation creates additional problems in terms of care and support. Also, disturbing is the limited access to anti-retroviral therapy. While no figure are available for the delta, the world Health Organisation estimates that only one percent of African living with HIV can obtain these drugs.

According to the 2003 national sentinel survey, the prevalence rates in the south-south region of Nigeria are higher in urban than in rural areas. Six of the Niger Delta states are within this region. In the south-west, where Ondo state is located, urban prevalence is also higher. The picture according to the survey is different in the south east, where HIV and AIDS rates are higher in rural than in urban areas.

Data further show that in the south-south zone, the 20-24 age bracket displayed the highest prevalence, at 8.9 percent closely followed by the 25-29 age bracket group with seven percent. The lowest prevalence of 1.7 percent was in the 15-19 age bracket. There was a consistent fall from 20-24 year olds down to 40-49 year-olds. The high prevalence among younger people underscores the serious threat the epidemic poses to productivity now and in the future.

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In Nigeria and the Niger Delta, the dominant form of transmission of hiv is through heterosexual sex. Prevalence rates are higher for women (especially those aged 15-24 years) than for men, as are employment truncation rates. The gender patterns according to Gaigbe-togbe et al (2003) signify that traditional practices such as polygamy, the holding of concubines and permissive male sexual norms operate to make women move vulnerable (Nkwi, 2004). Evidence from ERML (1997) shows that the level of social exclusion and stigma is still high in the region. Women face a double vulnerability the links between poverty and exclusion and HIV and AIDS.

Factors promoting the epidemic

The factors behind the spread of HIV and AIDS in the region of study can be broadly categorized as behavioural, economic, socio-cultural and biological, although there are significant overlaps in causes and effect (erml, 2005).

Behavioural factors

Due to the fact that the dominant mode of transmission of Hiv virus is by heterosexual intercourse, one of the behavioural factors fanning the epidemic is the common practice of having multiple sexual partners. This tendency is common in all the Niger delta states for both men and women. The practice cuts across men of varying classes but for women, it is predominant among those from lower socio-economic backgrounds. Oil wealth encourages men to take advantage of their perceived economic buoyancy by engaging in sexual intercourse with many girls, often without protection (ERML, 2005). This confirms earlier finding from the 2003 NDHS, which noted that 70.6 percent of women and 94.5 percent of men sampled from the region revealed that they engaged in high risk sex in the 12 months preceding the survey. Many men have sex with sex workers, and sex at young ages is also common (NDHS 2003: 190-192).

Men's vulnerability is exacerbated by the type of work they engage in. Some jobs entails a lot of mobility such as being a long-distance driver or oil workers. The work schedule of oil workers makes them prone to the risk of HIV, because most are forced to stay away from their wives or regular sexual partners for up to one month, while engaged in exploratory and production activities (Orubuloye, 1995).

Oil industry jobs in particular have spurred migrations within the delta and attracted a mass of influx of people from outside. Migration has spawned urban squalor and overcrowding, child labour (Oloko, 2002); thriving commercial sex (Olusanya et al 1986; Adedoyin et al, 1995; Omorodion, 1994); the proliferation of sub-standard health care faculties including quacks

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masquerading as health care agents; and abject poverty. These factors encourage risky sexual behaviour and lifestyles contributing to the spread of HIV and AIDS.

In urban centres such as Port Harcourt, Warri, Benin city, overcrowded housing units have become the breeding ground for sexual activities among neighbours and between older men and the children/ wards of their neighbours. There are reports of widespread unprotected sexual intercourse between older men and girl hawkers (Erinosho, 2004).the Nigerian of girls and women from Edo State, in particular to other parts of the world for commercial sex work has been documented by Onyeononu (2003). This migratory patterns spreads HIV and AIDS not only in Edo state, but in the whole of the Niger delta and beyond.

Economic factors

Poverty and HIV and AIDS are closely related. Poverty prevents the establishment of needed prevention, care, support and treatment programmes. Poverty also reduces access to information, education and services that could reduce the spread of the virus (UNFPA, 2002) HIV & AIDS also generates poverty. As those with the virus fall ill and die, a family or community loses much needed human capital or productive resources. The Niger delta poverty has been one of the main propellants of the spread of HIV and AIDS (Makinwa – Adeboye, 19991, Orubuloye et al 1999, oloko et al (1993) Omorodian (1993) oloko et al (1993) makinwa- adebusoye and odumosu (1997), isiuyo-abanihe et al 1998). It also aggrevates the already harsh repercussions of having the HIV virus.

Poverty drives the poor to seek health care from assorted health care agents who are usually quacks (Erinosho, 2004), including patents medical sellers. They are likely to use infected needles for intravenous injections. Traditional healers who constitute a formidable sub-group among health care providers in all states of the Niger delta, often use unsterilized blades and knives for incisions on their clients, in order to protect them from diabolical attacks. They pose a serious threat to social and physical well-being. The abuse of blood products is also rife within the region. Blood transfusion is extremely risky because the skills and facilities needed to screen blood products are either not available or have deteriorated and/or broken down. This is particularly true in the riverine areas, which are inaccessible by road and have suffered from years of infrastructural neglect by the federal, state and local governments (NDHS, 2003).

The drive for economic development has unfortunately helped the spread of HIV and AIDS. In cross river state, which has the country's highest HIV and AIDS prevalence, there is apprehension that tourism might increase the spread of HIV if adequate safeguards are not in place (and that conversely HIV could undermine development aspirations in tourism).

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Socio- cultural factors

Two kinds of socio- cultural factors related to HIV and aids can be identified. Those embedded in the social structure (macro- sociological) and those that can be regarded as the externalities or unintended consequences of rapid modernization following the discovery of oil and gas in the region. The latter have become part of the socio- cultural milieu (micro-sociological). The delta's oil economy has generated severe moral contradictions by creating a class of rich exploiters who take advantage of the endemic poverty to flaunt their wealth, seduce impoverished adolescent girls and generally gain access to an extensive network of female sexual partners. Adolescent females engage in transactional sex activities has become an important mode for the heterosexual transmission of HIV from the mid-1980s onwards.

Social instability resulting from skewed development has meant high unemployment rates for restive youths, many of whom turn to violence. Education systems have become destabilized and employment patterns more precarious, paving the way for behaviour that transmits the virus. Social beliefs affect understanding of the causes and prevention of HIV and AIDS, as well as practices to spread or stop the virus. For most people in the region, the disease is a "punishment from god and the handy work of witchcraft". Research shows that many people do not have correct information about the transmission and prevention of HIV and AIDS, as well as the risk associated with it. Available data reveal that women's and men's knowledge of HIV and AIDS is grossly deficient in both urban and rural areas of the Niger Delta (ERML, 2003). The modes of transmission known and shared by all are unprotected sexual intercourse with an infected person and sharing of needles. But their knowledge of other transmission routes as well as the associated risks of HIV infections is low.

Given the low level of understanding about HIV and AIDS in the Niger Delta, it is not surprising that a significant of people believe that HIV and AIDS can be prevented and / or cured by traditional healers and medicines. Some take risk when they consume concoctions before or after sex that they believe are sure antidotes to HIV. Many people in the Niger Delta simply believe that the disease is not real. The 2003 NDHS corroborates this view. In the south-south region, it reveals that about 10 percent of women and eight percent of men have yet to hear about HIV and AIDS. It is also evident that knowledge about HIV prevention is very low. Only 47.1 percent of women and 49.8 percent of men knew about prevention techniques such as using condoms and limiting sex to one unifected partner. The social stigma attached to carriers of HIV and aids has also hampered efforts to curb the spread of the disease.

In the Niger Delta, as in most regions of Nigeria, harmful traditional practices add an extra dimension of risk in contracting. HIV. These include Female Genital Mutilation (FGM), widowhood rites and body scarification. FGM, which is widespread in some parts of the Niger

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delta, is usually performed by traditional healers or circumcisers. This custom is particularly rampant in some areas of Ondo, Edo and Delta state. FGM can cause serious consequences including death from excessive bleeding, as well as from the use of un-sterilized equipment that spreads HIV and other infections.

Another socially approved traditional practices in the Niger delta that can foster sexually transmitted diseases (STDs) is polygyny. This custom is rooted in the patriarchal nature of Nigerian society and promotes multiple sexual partners. About a quarter of married people in Nigeria are in polgynous unions (National Population Commission, 2000). The practice is prevalent in the Niger delta, especially in Ondo, Edo and Delta states. Another widowhood rite linked to HIV and AIDS in the Niger delta is levirate, otherwise known as wife inheritance(Owasanoye 1997, Inter-African Committee 2000). In the Niger delta as in other areas of Nigeria, the husband is usually the administrator of a woman's fertility, acquired through the payment of bride wealth. His death does not nullify the marriage. Instead, it opens access and control of the widows fertility to some other well-defined member(s) of the lineage, even if the deceased died of aids. Levirate practice have been documented in ondo, edo, delta, Akwa Ibom, Cross River and Imo states Inter African Committee 2000).

Gender relationships and HIV and AIDS

Gender relationships are of great social significance in the spread of HIV and aids. Studies reveal that HIV prevalence is typically higher among females- about 55 percent of adults living with HIV and AIDS in Africa are women (UNAIDS, 2000:3). The majority were infected by age 25, with women's peak infection rates often occurring at earlier ages than those of men. In the Niger delta, HIV and AIDS prevalence is also higher among young people and women. Gender issues are of prime importance (Olawoye, 2004) in women's heightened vulnerability, which stems from biological, socio- cultural and economic factors.

Power relationships and decision making in marriages, particularly in polygynous unions, are conducive to the spread of HIV and AIDS among women, since a man has statutory sexual privileges and access to more than a single female partner. Women in all economic levels in many Niger delta societies are expected to be passive sexually, because it is often considered improper for women to demonstrate sexual knowledge. Even when women are provided with knowledge about HIV and AIDS, its transmission and how to protect themselves, they often feel too inhibited to share this information with their partners, unable to participate in meaningful communication about sexuality (Olawoye, 2004), they are not able to protect themselves with abstinence, mutual fidelity or condoms (Richardson 1990). Once women acquire HIV, the communal and lineage ideologies of male preference make it less likely that meager family or

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household incomes will be expended on treatment for them, especially if they are not regarded as major contributors to those incomes.

Also, in the Niger Delta, as in most other places in Africa, women are under great pressure to demonstrate their fertility and become mothers. This goal of childbearing is often incompatible with safer sex practices. Some women establish outside relationships to have babies when they perceive that their husbands are not in a position to impregnate them. Women want to save themselves from the embarrassment and scorn heaped upon women who are childless in Nigeria society. Social harassment, sexual coercion and exploitation in schools and the work place also make women and girls vulnerable to HIV and AIDS. Many schoolgirls are coerced and exploited by teachers and older men. The phenomena of sugar daddies has been a terrible development. (Olawoye, 2004).

Biological factors

The differences in prevalence's rates between men and women can be partly accounted for by their biological differences. During sexual intercourse, abrasions or injuries in the vagina are more than those on the penis, particularly during violent or coerced sex. This is more serious in the case of younger girls whose vaginal canals are not fully developed and are prone to tears and abrasions. Women tend to have a higher rate of genital ulcers, which facilitates HIV transmission (ERML, 2005).

Impacts of HIV and AIDS on key sectors

HIV and AIDS touches every sector of the Niger Delta economy. In agriculture, for example, when HIV and aids strikes farmers, the reduced cultivation of cash crops and food products is the result. Although it is difficult to precisely define the shortfall in crop production attributable to HIV and AIDS primary data collected indicates that many farmers have died of diseases related to aids (ERML 2005).

In the economic and business spheres, HIV and AIDS has exacerbated the already severe shortage of qualified men and women. Days of labour are lost to illness, productivity drops and funeral and health costs increase (UNDP,2006). Accordingly, households have to slash their spendings on education to pay for health care.

The impact of HIV and AIDS on education is severe. It reduced the supply of teachers, the resources for education, and the demand for education by children. The withdrawal of children from school in response to increase expenditures on and care requirements for sick family members was commonly observed in the course of the study. Some children even become

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breadwinners when the heads of the family are incapacitated by sickness or die (UNESCO 2003). The quality of education suffers through teachers' absenteeism.

The impact of HIV and AIDS on the health sector is felt in the increased demand for care. In the region, already weak health systems are overstretched, and the cost are rising for infrastructure, drugs and personnel. Other concerns include the growing increase in the number of orphans and widespread premature death, which is radically altering life expectancy. A Nigerian child can now expect to die before his or her 41st birthday, according to the human development report on Nigeria (UNDP, 2005)

CONCLUSION AND RECOMMENDATIONS

Nigeria's HIV prevalence rate remains relatively high, especially for younger people. The fact is that addressing HIV and AIDS requires a holistic approach that encapsulates both treating the symptoms and addressing the underlying causes. Viewing HIV and AIDS as development problem allows for an understanding of the complexity of the issues at stake and the identification of actions across different sectors. Essential to this process is the establishment of partnerships to stop the HIV and AIDS pandemic. The organized private sector with its abundant resources should be mobilized to support HIV and AIDS programming for example. At minimum, business should develop programmes for their staff. Private sector organizations could also contribute to advocacy work, counselling and health care services.

Specific strategies and programmes to address all facets of HIV should include:-

- Strong policy advocacy from top level policy makers and opinion leaders should accompany public awareness campaigns about the multidimensional nature of HIV and AIDS.

- Reducing vulnerability related to economic factors urgently requires strategies to provide sustainable livelihoods and the implementation of a human development agenda.

- Since gender inequality plays significant role in spreading HIV, all forms of gender discrimination should be discouraged.

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- Heterogeneous sex is very popular among youths in the Niger Delta. They should be a particular focus of behaviour change campaigns.

- Workplace policies on HIV should be encouraged in public and private institutions with particular emphasis on issues relating to stigma and discrimination against people living with HIV and AIDS.

- Special programmes should assist orphans and vulnerable children, including through the provision of free health care and education. Both the state and local governments should be responsible for this.

- Oil companies should include HIV and AIDS assistance within their social responsibility and community development activities.

The dearth of health care and HIV and AIDS facilities is a matter of urgent concern in the Niger delta. The shortage of voluntary counseling and testing centres, services for the prevention of mother- to – child transmission and distribution points for anti- retroviral drugs should be addressed collectively, with state and local governments in the drivers seat and the development agency in the region as the overall coordinator for the region.

REFERENCES

Adedoyin, m. And a. A. Adegoke (1995) teenage prostitution – child survey of the IIorin situation; African journal of medicine and medical sciences, 1 (24 march) pp27-31.

Alubo o. A. Zwander t. Jolayemi and e. Omodu (2002) “acceptance and sensitisation of plwa in Nigeria, aids care 14(1), pp 117-121.

Erinosho l (2003) “gender issues in the prevention and control of STIs and HIV/AIDS. Lesson from Awka and Agulu, Anambra state, Nigeria; African journal of reproductive health 7 (2) pp 89-99.

ISSN: 2455-8834

Volume:01, Issue:04

Eriuosho, l. (2004) "socio economic and cultural factors in the spread of HIV/AIDS; paper presented at the international. Seminar on preventing HIV and AIDS in Nigerian communities: strengthening institutional responses, 8-11 december.

Erinosho l (2004) gender issues in HIV and AIDS prevention and control; a paper presented at the strategic skills development programme for NGOS, social sciences and Reproductive health research network, Ibandan 9-15 may.

Erml (1997) Environmental and socio=economic characteristics of the Niger Delta.

Erml(2003) Environmental and socio-economic characteristics of the Niger delta. Erml (2005) Environmental and socio-economic characteristics of the Niger delta,

Gaigbe-togbe, victor and Mary weinberger (2003) "the social and economic implications of HIV-AIDS, a paper presented at the fourth conference on african population and poverty on african population and poverty in Africa, turnis 8-12 December

Government of Nigeria (1999) national sentinel survey. Government of Nigeria (2002), national sentinel survey, 2002.

Inter- African committee (2000), rights and widowhood rites in Nigeria, Lagos.

Isiugo – abanihe u. C. And s. O. Odiagbe (1998) sexual behaviour on the highway: Nigerian truckers and commercial sex workers in the era of aids; African population studies 13 (2) pp.14-54.

Makinwa- adebusoye, p (1991);Adolescent reproductive behaviour in Nigeria. Research study of five cities: Niser monograph series n0. 3.

Ola j. (2004) gender issues and HIV and AIDS, a paper presented at the leadership in hiv and aids programming workshop for youths; social science and reproductive health research network, Ibandan, 5 october.

Makinwa- adebusoye p. And o. Odumosu (1999) sexual behaviour and reproductive health. Attitudes and practices among adolescent in Nigeria. Findings from recent focus group discussions' research for development (1) (2) pp 81-92.

ISSN: 2455-8834

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National population commission (2000) Nigeria Demographic and Health survey, Calverton, Marylan.

Nkwi, p. N. (2004) "the impact of cultural practices on the spread of HIV/ AIDS: an anthropological study of selected countries in Sub-saharan Africa, a paper presented at the international seminar on preventing hiv / aids in Nigerian communities: strengthening institutional responses, 8-11 December.

Oloko s. A. And a. O. Omoboye (1993) "sexual networking among some Lagos state adolescent Yoruba students: health transition review, supplement to volumes 3, pp. 151-157.

Omorodion f (1993) sexual networking among market women in Benin city, Bendel state. Nigeria; health transition Review, supplement to volume 3 pp 159-169.

Omorodion F (1994) child sexual abuse in Benin city, Edo state, Nigeria. A sociological analysis. Issues in comprehensive nursing (17 march) pp 29-36.

Orubuleye j. O. (1995) patterns of sexual behaviour of high- risk population and the implication for stds as hiv and aids transmission in nigeria; in richard g, parker and john h. Gorgon eds, conceiving sexuality, new york and london: rutledge, pp 235-246.

Orubuleye j. O., j. O. Caldwell and p. Cad well (1992) diffusion and focus in sexual networking: identifying partners and partners.

Owasanoye, b and b. Akons (1997), widowhood in nigeria issues, problems and prospects, Lagos. Federick ebert foundation.

Oyeneye, o. Y. And s. Kawornise (1993) sexual networking in ijebu-ode, nigeria: an exploratory study; health transition review, supplement to volume 3, pp 171-183.

Richardson, Diane (1990) aids education and women sexual and reproductive issues in Peter Aggletou, peter Davies and Graham Hart eds. AIDS; individual cultural and policy dimensions, London and New York: The Falmer press, pp 169-179.

ISSN: 2455-8834

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Social sciences and reproductive health research network (2001); gender socialization and male responsibility in the family: a comparative analysis of three socio-cultural groups in Nigeria, annals of the social sciences academy of Nigeria 13 (January / December), pp. 99-108.

UNAIDS (2002) workshop on HIV /AIDS Advocate and Media Networks', Nairobi, 29 July to 2 august.

UNDP (2005) HIV/AIDS and Human Development thematic guidance note, NHDR occasional paper 4, New York: Human Development Report office.

UNDP (2004) human development report: HIV and AIDS a challenge to sustainable Human Development, Lagos.

United Nations Educational, Scientific and Cultural Organisation (UNESCO (2003), education in the context of hiv/aids. A resource book Abuja.

UNDP (2006) Niger Delta Human Development Report, Abuja.

